CHAPTER 1: GENERAL INFORMATION

UNIT 4: HIGHMARK MEMBER INFORMATION

IN THIS UNIT

What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**

The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.

The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.

The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

1.4 UNIT DEFINITIONS

Member	A **member** is an individual who is enrolled in a health plan and who meets the eligibility requirements of the program.
Subscriber	A **subscriber** is a member whose employment or other status, except for family dependency, is the basis for eligibility for enrollment in a program.
Dependent	A **dependent** is any member of a subscriber's family who meets the applicable eligibility requirements and is enrolled in a program.
Managed care plans	**Managed care plans** are delivered through the use of a provider network. Under some plans, members may visit providers in or out of network; however, the highest level of benefits are paid for visits to in-network providers. Managed care plans include: Health Maintenance Organizations (HMOs); Point of Service (POS); Open Access; Preferred Provider Organizations (PPOs); and Exclusive Provider Organizations (EPOs).
Indemnity plans	**Traditional indemnity** plans are sometimes referred to as fee-for-service plans in that they pay a set amount per health care service performed. It gives members the widest choice of physicians and services through participating providers. Generally, these plans are subject to a deductible and coinsurance.

1.4 IDENTIFYING HIGHMARK MEMBERS

Overview

A Highmark member can be easily identified by the information on his or her identification (ID) card. Always ask to see the ID card upon the patient's first visit. On subsequent visits, ask the patient if he or she has had a change in health insurance. A patient's insurance information can change at any time and incorrect information can result in delayed claim payment.

Although the ID card provides enrollment information for a Highmark member, it is recommended that you always confirm eligibility for the date of service through NaviNet,® Highmark's Internet-based inquiry system, or by performing an electronic HIPAA 270 Eligibility/Benefit Inquiry transaction.

Member ID cards

All Highmark members receive an identification card so you can easily identify them and have essential information in order to help you understand their coverage. The identification cards may have slight variations depending upon the type of program and the location of the Blue Plan through which members are enrolled. There may also be some small variances on cards of each employer group.

Practices with the fewest claim submission errors generally require the member to show the current ID card with each visit and verify eligibility on every visit/service. This is why it is important that you check the member's identification card prior to each visit or service you provide.

Generally, the identification card includes the following information:

- Subscriber's name;
- Dependent's name, if applicable;
- Member's Unique Member Identifier (UMI), or "Member ID," which includes a 3-character prefix and a 12-digit identification number;
- Group number – a series of alphabetical and numeric characters assigned to employment groups, professional associations, and direct payment programs;
- Plan Code – three digits that identify the Blue Plan through which the member is enrolled;
- Type of agreement – a brief description of the type of agreements and coverage of the member. Not all identification cards have this information;
- BlueCard® – all BlueCard members can be identified by a 3-character prefix preceding the member identification number on their identification card. Always report the 3-character prefix from any ID card.

Members may have more than one identification card if they are covered under more than one plan. Please verify the correct prefix and identification number for reporting services.

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1.4 IDENTIFYING HIGHMARK MEMBERS, Continued

Prefix (formerly "alpha prefix")

The 3-character prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The prefix has historically been an "alpha prefix" – with all alpha characters. Beginning in 2018, the Blue Cross Blue Shield Association (BCBSA) started issuing "alphanumeric prefixes" to Blue Plans since the options for 3-character all alpha combinations were running low.

Effective January 1, 2019, Highmark has new group plans that have been assigned alphanumeric prefixes. Please be aware that you may be seeing local Highmark members with valid alphanumeric prefixes on their Member ID cards. Since existing prefixes will not change, you will also continue to see the familiar "alpha prefixes."

Please see the manual's **Chapter 2.6: The BlueCard Program**, section titled "How to Identify BlueCard Members," for more information on the BCBSA transition of "alpha prefixes" to the 3-character prefixes that can be either three alpha characters or a combination of alpha and numeric characters.

IMPORTANT! Medicare Advantage

Medicare Advantage members retain their Medicare cards even after they begin coverage under Highmark Medicare Advantage products. You should always ask Medicare-eligible patients if they have joined a Highmark Medicare Advantage plan and, if they have, request their Highmark Medicare Advantage ID card.

For new members without an ID card

If a new Highmark member comes to the office and has not yet received an identification card, they may present an enrollment form or, for Medicare Advantage, a letter of confirmation in lieu of an ID card.

What Is My Service Area?

FOR MORE INFORMATION

Please see the next section of this unit for more information and examples of Member ID cards.

1.4 MEMBER IDENTIFICATION CARDS

Overview

Identification cards are issued to all Highmark subscribers and their dependents. The ID cards feature a simplified format with key information regarding benefits and eligibility. Blue Cross and Blue Shield Association (BCBSA) regulations require subscriber identification cards of all Blue Plans to follow the same format. Highmark's member identification cards satisfy BCBSA requirements.

Design features

The BCBSA required design features of the identification card include:

- **Background color:** The background of the card must be white only.
- **Easily identifiable standardized "zones" for display of information:** The front of the card features eight easily identifiable zones, while the back is divided into five zones. Horizontal black lines mark divisions among zones.
- **Blue Plan name and logo:** The Highmark company name and logo appears on the left side of the top section of the ID card.
- **Member Name and Member ID:** The member name followed by the member identification number will always appear below the Highmark logo.
- **Name of the product under which the member has coverage:** The member's Highmark product is displayed on the right side of the top section of the ID card. An employer group name may also appear here.
- **Blue Cross Blue Shield Association's "suitcase" logo:** The suitcase logo, identifying BlueCard participation, appears in the lower right corner.
- **Prescription Drug Program group number:** This number appears on the front of the card, in the third zone on the left, along with the member's medical Group Number and the Blue Cross/Blue Shield Plan Area Code.
- **PCP:** The PCP name will appear if a valid PCP has been chosen.
- **ID cards for dependents:** Both the subscriber and dependent information appears on a dependent's ID card. Subscriber information is on the left side of the front of the card while dependent information is on the right.
- **Copays:** Copays -- such as PCP, Office Visit, Specialist Visit, Emergency Room -- may appear if applicable.
- **Coverage effective date information on individual products ("Direct Pay"):** This information is no longer provided on the ID card for members with employer-sponsored coverage.
- **Back of card:** The applicable Blue Cross and/or Blue Shield symbols will be at the top. The Internet address of the Blue Plan must appear in bold-face type on the right side of the top section of the ID card, with all relevant telephone numbers in bold-face type below it.

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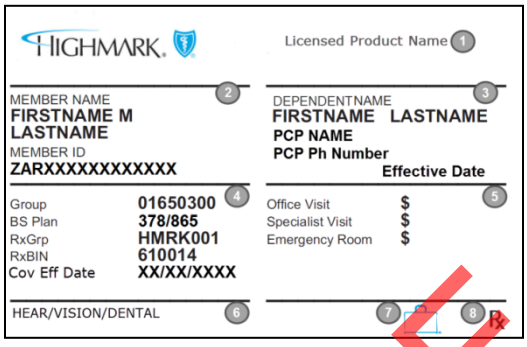
1.4 MEMBER IDENTIFICATION CARDS, Continued

Front of a standard Member ID card

The Highmark company name/logo will always appear on the left side of the top section of the front of the ID card.



Other areas will be populated as follows (numbers correspond to numbered areas on the sample ID card above):

1. **Licensed Product Name:** The product name, such as *PPO Blue* or *Community Blue PPO*, will appear here and will help you determine which network rules to follow.
2. **Member Identification Information:**
   a. The Member Name is the individual, or "subscriber," under whose name the coverage was established.
   b. The member's identification number, or Member ID," includes the 3-character prefix that varies by employer group or account (not applicable to Medicare Advantage products).
3. **Dependent and PCP Information** (if applicable)**:**
   a. Both the subscriber and dependent information will appear on a dependent's ID card, with the dependent's name in this section on the right. Always verify that you have the card that corresponds with your patient and not that of another family member/dependent.
   b. The PCP's name will appear here if a valid PCP is chosen.
4. **Medical and Pharmacy Claims Processing Information:**
   a. The group number identifies the member's medical group.
   b. The 3-digit Plan Codes identify the corresponding Blue Plan.
   c. The RxGrp/RxBIN numbers identify the applicable prescription coverage information.
5. **Member Cost Sharing:**
   a. PCP, specialist office, office visit, and/or emergency room copayments may be listed. Specialist copays may not be the same for behavioral health care services, therapies, or diagnostic services; those copayments may be found via NaviNet® or by calling the phone number on the back of the ID card.
   b. Pharmacy copayments are not listed. Participating pharmacies can verify copayment amounts online.

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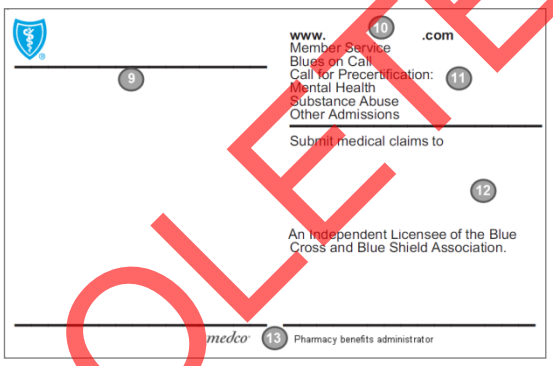
1.4 MEMBER IDENTIFICATION CARDS, Continued

Front of a standard Member ID card

6. **Additional Coverage Information:** Other coverage information may be indicated here, such as hearing, vision, and/or dental.
7. **Suitcase Logo:** Indicates a member of the BlueCard® program. For more information about BlueCard, please refer to **Chapter 2.6: The BlueCard Program** of the *Highmark Provider Manual*.
8. **Rx Logo:** This will be on the ID card whenever a Highmark prescription drug program is included.

The back of the member's ID card

The back of the member's identification card contains information mainly for the member's use. The information may differ based on the product and may include, but is not limited to, the information outlined below.



9. **Plan Specific Information:** Benefit and administrative information specific to Highmark and/or the member's coverage such as advising the member how to receive the highest level of benefits by obtaining care from an in-network provider.
10. **Plan Website:** Identifies the Blue Plan's website address to access Plan information online.
11. **Plan Contact Information:**
    a. Blues On Call phone number to call for health education and support services including myCare Navigator, if applicable.
    b. Member Service phone number for members to call Highmark with questions about benefits, claims, etc.
    c. Additional telephone numbers for members to receive assistance in obtaining admission to non-participating hospitals, facilities, mental health and substance abuse treatment programs, etc.
12. **Claim Submission Information and Independent Licensee Disclosure:** Lists addresses for member submitted claims. The "tag line" identifying Highmark as an independent licensee of the Blue Cross Blue Shield Association will be located in this space.
13. **Pharmacy Benefits Administrator and Logo:** The name and logo of the pharmacy benefits administrator may appear here if applicable.

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1.4 MEMBER IDENTIFICATION CARDS, Continued

Examples of Highmark Member ID cards

The Blue Cross and Blue Shield Association (BCBSA) regulations require that all subscriber identification cards be in the requisite format. Therefore, you should accept only those cards in the design format described within this unit.

Click on the link for your region to view samples of Highmark's ID cards:

- **Pennsylvania Western Region ID Card Samples**
- **Pennsylvania Central Region ID Card Sample**
- **Highmark Delaware ID Card Sample**
- **Highmark West Virginia ID Card Samples**

What Is My Service Area?

1.4 VERIFYING ELIGIBILITY AND BENEFITS

Overview

It is the responsibility of the provider to verify that the member's benefit plan provides the appropriate benefits for the anticipated date of service prior to rendering service. Highmark recommends that providers confirm a member's eligibility on the anticipated date of service or one business day prior to the anticipated date of service.

You can verify a Highmark member's coverage by using NaviNet,® performing an electronic HIPAA 270 Eligibility/Benefit Inquiry transaction, or by calling the Provider Service Center.

NaviNet®

NaviNet® is our primary resource for providers to obtain their data on Highmark members. This Internet-based service enables you to access enrollment and benefits information, claim status, program allowances, and accounts receivable management as well as many other sources that will help you to find information about your Highmark patients.

This time-saving service is provided free of charge to participating providers in Pennsylvania, Delaware, and West Virginia. If you are NaviNet-enabled, NaviNet is the required method to check benefits and eligibility.

Please visit **Chapter 1.3: Electronic Solutions -- EDI & NaviNet** for more information about NaviNet.

What Is My Service Area?

HIPAA 270 Eligibility and Benefit Inquiry transaction

Highmark's Electronic Data Interchange (EDI) transaction system supports transactions adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Eligibility and benefits for Highmark members can be verified by performing an electronic HIPAA 270 Eligibility/Benefit Inquiry transaction.

For more information on electronic connectivity with Highmark, select the link titled **Electronic Data Interchange (EDI) Services** from the Provider Resource Center main menu, or by clicking the applicable link below to access the site directly:

- Pennsylvania: **highmark.com/edi**
- Delaware: **highmark.com/edi-bcbsde**
- West Virginia: **highmark.com/edi-wv**

You may contact the EDI Operations support line at **1-800-992-0246.**

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1.4 VERIFYING ELIGIBILITY AND BENEFITS, Continued

Provider Service Center

For those providers who are not NaviNet-enabled or without electronic capabilities, Provider Service Center customer service representatives are available to provide information about Highmark member eligibility and benefits.

For Provider Service Center contact information in your region, please see the manual's **Chapter 1.2: Online Resources & Contact Information** or access the **Quick Reference**, which can always be found at the top of the manual's home page.

Please note that the "Quick Reference" icon is placed in key locations throughout the manual to provide easy access to phone numbers for the Provider Service Center and Highmark Clinical Services.

Verifying eligibility for BlueCard® members

To verify eligibility for BlueCard® members, please use the **Blue Exchange® Eligibility and Benefits Inquiry** on NaviNet, or call **1-800-676-BLUE**.

For additional information about BlueCard, please see the manual's **Chapter 2.6: The BlueCard Program**. Additional information is also available in the BlueCard Information Center on the Provider Resource Center – select **INTER-PLAN PROGRAMS** from the main menu.

Limitations

It is a member's responsibility to timely notify his/her employer of eligibility changes (e.g., divorce, loss of student status) and the group's responsibility to notify Highmark timely of such changes. Highmark cannot accurately verify eligibility if the member or group does not timely notify us of eligibility changes.

On rare occasions, an insured group may be terminated retroactively by Highmark for non-payment of premiums (groups are allowed at least a thirty [30] day grace period for payment of premiums). Similarly, a self-funded group may be terminated retroactively for non-payment of claims or administrative expenses. In both cases, eligibility of the members is terminated as of the date the group is terminated. In all cases, a provider may bill the patient directly for the cost of any services provided after the effective date of termination. Also, Highmark may terminate an individual member retroactive to the last day of the month the individual was eligible.

1.4 DEPENDENT ELIGIBILITY

Health Care Reform (HCR)

The Patient Protection & Affordable Care Act (PPACA) is a federal law, enacted on March 23, 2010, that makes health insurance coverage available to all Americans. The provisions in the new law are collectively referred to as Health Care Reform (HCR).

One of the many provisions of the law requires that all health benefit plans provide coverage for dependents on their parents' policy up to age twenty-six (26) years. Effective September 23, 2010, all health plans (individual and group health insurance, including self-funded plans) that cover children as dependents must continue to make that coverage available until the adult dependent reaches age 26 regardless of whether the adult dependent is married or a student.

Act 4 of 2009: Health Insurance Coverage for Adult Children

PA ONLY

Pennsylvania Act 4 of 2009, Health Insurance Coverage for Adult Children, expands health insurance coverage for children of insured parents. It allows adults up to age thirty (30), under certain conditions, to remain covered by their parents' health insurance. It is a state mandate that gives employer groups the option to extend health insurance coverage to the children of their employees up to and including age twenty-nine (29) years.

While Act 4 provides an opportunity for many young adults to obtain health insurance, it does not require that employers offer coverage to adult children of their employees. Act 4 does require licensed insurers to offer employer groups this option at the insured employee's expense.

What Is My Service Area?

Verifying dependent eligibility

The changes in dependent eligibility will be relatively seamless for providers. Adult dependents with coverage under their parents' agreement will have a Highmark ID card providing the applicable member identification number.

As always, request the member's ID card on each visit, and then verify coverage and benefits through the NaviNet® **Eligibility and Benefits** function. NaviNet is the preferred tool for inquiring about Highmark member information. NaviNet-enabled providers are expected to use this tool for all routine eligibility, benefit, and claim status inquiries.

For those providers not NaviNet-enabled, eligibility can be verified by submitting a HIPAA 270 Eligibility/Benefit Inquiry transaction or by calling the Provider Service Center. Please see **Chapter 1.2: Online Resources & Contact Information** for more information on contacting Provider Services in your region.

1.4 CONFIDENTIALITY OF MEMBER INFORMATION

Confidentiality policy

In accordance with the highest standards of professionalism, and as a requirement of all provider contracts, providers are obligated to protect the personal health information of their Highmark members from unauthorized or inappropriate use.

Member rights and responsibilities

Highmark treats members in a manner that respects their rights and will clearly communicate Highmark's expectations of our member responsibilities. Please see **Chapter 1.5: Member Rights & Responsibilities** to review our members' rights and responsibilities.

Normal business operation

The Health Insurance Portability and Accountability (HIPAA) Privacy Rule allows Highmark to use and disclose members' protected health information (PHI) for treatment, payment, and health care operations. Examples include:

- Claims management
- Certain types of routine audits by Highmark's group customers
- Coordination of care
- Quality assessment and measurement
- Case management
- Utilization review
- Performance measurement
- Customer service
- Credentialing
- Medical review
- Underwriting

Release of information for non-routine use

If member information is needed for reasons other than those listed above, Highmark must obtain the member's consent via an *Authorization for Disclosure* form.

If a member is unable to give informed consent, Highmark has a process to obtain this permission through a parent or legal guardian signature, signature by next of kin, or attorney-in-fact. The member has the right to limit the purposes for which the information can be used and all concerned are obligated to respect that expressed limitation.

Internal and external controls

Members of Highmark products benefit from the many safeguards Highmark has in place to protect the use of data it maintains. This includes: comprehensive privacy and security training of members of Highmark's workforce; requiring Highmark employees to sign statements in which they agree to protect members' confidentiality; using computer passwords to limit access to members' PHI; and including confidentiality language in our contracts with doctors, hospitals, vendors, and other health care providers.

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1.4 CONFIDENTIALITY OF MEMBER INFORMATION, Continued

Providers' responsibility to protect PHI	Members must not be interviewed about medical, financial, or other private matters within the hearing range of other patients. Practitioners must have procedures in place for informed consent and the storage and protection of medical records. Highmark will verify that these policies/procedures are in place as part of the onsite review process, when applicable.
Others who have occasion to use member data	As a condition of employment, all Highmark employees must sign a statement agreeing to hold member information in strict confidence. Physicians and all other Highmark participating providers are also bound by their contracts to comply with all state and federal laws protecting the privacy of members' personal health information. Highmark provides aggregate information to employer groups whenever possible.
Provider breach notification obligations	All personally identifiable information ("PII") about Highmark's Members ("Protected Health Information" or "PHI") is subject to state and federal statutory and regulatory privacy standards, including, without limitation, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act (the "HITECH ACT"), and regulations adopted thereunder by the U.S. Department of Health and Human Services, 45 C.F.R. Parts 160, 162, 164 ("the HIPAA Rules"). Provider has established a program to effectuate full compliance with all applicable state and federal privacy and breach notification laws including, without limitation, HIPAA, 45 CFR §§ 164.400-414 (the "HIPAA Breach Notification Rule,") and HITECH for the protection of PHI and PII, and for the notification of individuals, appropriate official bodies, and the media in the event of a breach of PHI or PII. Moreover, Provider will maintain its privacy compliance and breach notification program in accordance with industry best practices.
Member access to PHI	Members of Highmark products have a right to access (i.e., to review and/or obtain a copy of) their PHI that is contained in a designated record set. Generally, a "designated record set" contains medical and billing records as well as other records that are used to make decisions about our members' health care benefits. Therefore, each practitioner must have a mechanism in place to provide this access.
Use of measurement data	Through the use of measurement data, Highmark is able to manage members' health care needs through appropriate quality improvement programs such as health, wellness, and disease management programs.

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1.4 CONFIDENTIALITY OF MEMBER INFORMATION, Continued

Protection of information disclosed to plan sponsors or employers	Highmark, in general, will disclose PHI only to an authorized representative of a self-insured group health plan. However, Highmark may provide summary health and enrollment information, which has been aggregated and de-identified, to fully insured group health plans and plan sponsors.
The Privacy Department	Highmark's Privacy Department reviews and approves policies regarding the handling of PHI and other confidential information. Online privacy policy may be viewed at **highmark.com**. At the bottom of the page, click **Privacy**.

1.4 ADVISING MEMBERS OF TREATMENT OPTIONS

Policy

Highmark fully encourages and supports our network physicians' efforts to provide advice and counsel and to freely communicate with patients on all medically necessary treatment options available, including medication treatment options, regardless of benefit coverage limitations, that may be appropriate for the member's condition or disease.

In cases where the care, services, or supplies are needed from a provider who does not participate in Highmark's networks, authorization must be requested.

Members must make decisions based on a full disclosure of options, including potential insurance coverage. Disclosure is the obligation of the treating provider.

What Is My Service Area?

Background

Some managed care plans may include a "gag clause" in their provider contracts that limits a network physician's ability to provide full counsel and advice to enrollees.

Highmark network contracts for all products do not (and never did) contain such a "gag clause" relating to treatment advice, and, in Pennsylvania, complies with Act 68 requirements prohibiting such clauses.

Highmark fully encourages and supports our network physicians' efforts to provide advice and counsel, and to freely communicate on all medically viable treatment options available, including medication treatment options, which may be appropriate for the member's condition or disease regardless of benefit coverage limitations. Therefore, we do not penalize and have never penalized physicians for discussing medically appropriate care with the member.

1.4 MEMBER ACCESS TO PHYSICIANS AND FACILITIES

Accessibility expectations for providers

To stay healthy, members must be able to see their physicians when needed. To support this goal, we are sharing with you Highmark's expectations for accessibility of primary care physicians (PCPs), medical specialists, behavioral health specialists, and obstetricians. The standards set forth specific time frames in which network providers should respond to member needs based on symptoms.

Physicians are encouraged to see patients with scheduled appointments within fifteen (15) minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.

Note: *Standards for Pennsylvania Children's Health Insurance Program (CHIP) enrollees are available in* **Chaper 2.3: Other Government Programs** *and may differ from the expectations noted below.*

Why blue italics?

PCP AND MEDICAL SPECIALIST EXPECTATIONS	
Patient's Need:	**Performance Standard:**
Emergency/life threatening care • Sudden, life-threatening symptom(s) or condition requiring immediate medical treatment (e.g., chest pain, shortness of breath)	Immediate response
Urgent care appointments • An urgently needed service is a medical condition that requires rapid clinical intervention as a result of an unforeseen illness, injury, or condition (e.g., high fever, persistent vomiting/diarrhea)	Office visit within 1 day (24 hours)
Regular and routine care appointments • Non-urgent but in need of attention appointment (e.g., headache, cold, cough, rash, joint/muscle pain) • Routine wellness appointments (e.g., asymptomatic/preventive care, well child/patient exams, physical exams)	PA ONLY, WV ONLY: • Within 2-7 days (Non-urgent) • Within 30 days (Routine wellness) DE ONLY: Office visit within 3 weeks of member request
After-hours care • Access to practitioners after the practice's regular business hours	Acceptable process in place to respond 24 hours per day, 7 days a week to member issues (answering service that pages the practitioner or answering machine message telling caller how to reach the practitioner after hours)
In-office waiting times • Practitioners are encouraged to see patients with scheduled appointments within 15 minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.	Within 15 minutes

What Is My Service Area?

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1.4 MEMBER ACCESS TO PHYSICIANS AND FACILITIES, Continued

MATERNITY CARE EXPECTATIONS (Obstetrics)	
Patient's Need:	**Performance Standard:**
• Maternity Emergency	Immediate response
• Maternity 1st Trimester	Within 3 weeks of first request
• Maternity 2nd Trimester	Within 7 calendar days of first request
• Maternity 3rd Trimester	Within 3 calendar days of first request
• Maternity High Risk	Within 3 days of identification of high risk

What Is My Service Area?

BEHAVIORAL HEALTH SPECIALIST EXPECTATIONS		
Patient's Need:	**Performance Standard:**	
Care for a life-threatening emergency • Immediate intervention is required to prevent death or serious harm to patient or others	Immediate response	
Care for a non-life-threatening emergency • Rapid intervention is required to prevent acute deterioration of the patient's clinical state that compromises patient safety	Care within 6 hours	
Urgent care • Timely evaluation is needed to prevent deterioration of patient condition	Office visit within 48 hours	
Routine office visit • Patient's condition is considered to be stable	PA ONLY, WV ONLY	Office visit within 10 business days
	DE ONLY	Office visit within 7 calendar days
After-hours care • Access to practitioners after the practice's regular business hours	Acceptable process in place to respond 24 hours per day, 7 days a week to member issues (answering service that pages the practitioner or answering machine message telling caller how to reach the practitioner after hours)	
In-office waiting times • Practitioners are encouraged to see patients with scheduled appointments within 15 minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.	Within 15 minutes	

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1.4 MEMBER ACCESS TO PHYSICIANS AND FACILITIES, Continued

Acceptable after-hours methods

The chart below outlines acceptable methods of handling after-hours calls from your Highmark patients.

ANSWERING PROCESS	RESPONSE/MESSAGE	COMMENTS
Answering Service or Hospital Service	Caller transferred directly to physician	
	Service pages the physician on call (see comments)	A physician or clinical staff person is expected to return the call within 30 minutes.
Answering Machine	Message must provide the caller with a way to reach the physician on call by telephone or pager	Provide clear instructions on how to record a message on a pager (i.e., "you will hear a series of beeps, please enter your phone number, including area code, by pressing the number keys on your phone, then hang up"). A physician or clinical staff person is expected to return the call within 30 minutes.
	Instruct caller to leave a message (see comment)	A physician or clinical staff person is expected to return the call within 30 minutes.

Availability of facility services

Facility services need to be available to Highmark members on a twenty-four (24) hour per day, seven (7) day per week basis when medically appropriate and in accordance with industry standards.

Access to physician services is an integral component of the facility services provided to members. Physician services are provided by either hospital-based physicians or physicians employed by a facility. If physician services are provided to Highmark members on behalf of a facility, the facility must verify that physician has the appropriate training, education and licensure to provide such services.

Equal access and non-discrimination in treatment of members

In addition to requirements contained in your provider agreement and in any other applicable administrative requirements, network providers agree to requirements of equal access and non-discrimination of Highmark members within this manual.

Providers will provide members with equal access at all times to provider services. Providers agree not to discriminate in the treatment of Highmark members, or in the quality of services delivered, on the basis of place of residence, health status, race, color, ethnicity, national origin, religion, sex, age, mental or physical disability

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1.4 MEMBER ACCESS TO PHYSICIANS AND FACILITIES, Continued

Equal access and non-discrimination in treatment of members (continued)

or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, or source of payment. Further, providers shall not deny, limit, discriminate or condition the furnishing of provider services to members based on their known or believed relationship or association with an individual or individuals of a particular race, color, national origin, sex, age, or disability.

1.4 AFTER-HOURS PHSYICIAN ACCESSIBILITY STUDY

Monitoring accessibility

The After-Hours Physician Accessibility Study is one of the methods by which physicians are evaluated to determine whether they meet accessibility standards.

When the study is performed

Each practice meeting the following requirements participates in the after-hours study:

- New practice sites that have joined the network.
- An annual sample of existing practice site locations.
- Any practice site for which a member complaint (relating to after-hours access) has been received.
- Any provider who appeals a credentialing termination decision based on lack of 24/7 coverage.

Process

The table below describes the process for the after-hours accessibility study:

STEP	ACTION
1	A Highmark representative calls the practice's main telephone number after normal practice hours.
2	The Highmark representative verifies that the practice has an acceptable after hours process in place to respond to patient calls after regular business hours. Does the physician have an acceptable process? • If **YES**, no further action is necessary. • If **NO**, go to Step 3.
3	A letter is sent to the office informing them of the results and the need for a written corrective action plan. A Highmark representative contacts the office to discuss alternatives that the provider may use to be compliant with the after-hours requirements. Up to two follow-up calls are placed after regular hours to determine if the office has implemented corrective actions. **If the practice becomes compliant, a letter is forwarded to the practice acknowledging our appreciation for modifying their after-hours process.**

If you do not meet guidelines

Practices that remain non-compliant following Step 3 of the process may be subject to additional corrective action, sanctioning, and, ultimately, network termination.